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P. O. BOX

Update on the Happenings of HCFA's Managed Care Systems and Support Operations

Health Plan Payment and Operations Support, CHPP - Health Care Financing Administration

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PLAN COMMUNICATIONS LINKAGE UPDATE

Migration to the Medicare Data Communications Network (MDCN)

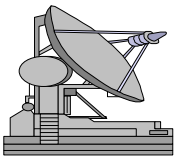
HCFA is requiring that all Medicare Managed Care Organizations (MCOs) establish a telecommunications link to the MDCN. In 1998, many of the risk-based MCOs were migrated to this network in order to submit encounter data required for the development of the risk adjustment factor. (The Balanced Budget Act mandated that for payment year 2000, M+C organizations - formerly risk-based HMOs - be paid on a risk adjustment basis. The first step in this process is the submittal of inpatient hospital diagnostic data.) In addition, all other Medicare business functions; i.e., the transmission of beneficiary enrollment, disenrollment and correction data and access to the Health Plan Management System (HPMS) must occur over the MDCN.

The MDCN is a telecommunications network that links HCFA with its fee-for-service contractors (carriers and intermediaries) and, now, the MCOs. It is maintained for HCFA by IBM Global Services (IGS). **The FTS2000 phone line service to the HCFA Data Center will be discontinued and all future access will be consolidated onto the MDCN.**

All remaining MCOs; i.e., those with cost, health plan prepayment, new M+C or demonstration contracts must migrate to the MDCN by July 1, 1999. An Operational Policy Letter (OPL) was released in April 1999, with instructions regarding this linkage. IGS will be contacting MCOs to discuss telecommunications options that best fit their current orientation and transmission volumes. **MDCN user IDs and passwords will be required in addition to the HCFA Data Center user IDs/passwords.**

Replacement of RLINK

RLINK users will be experiencing an additional change. HCFA is discontinuing support for the RLINK software because it fails to meet mandated security requirements. It will be replaced by a web browser-based TN3270 client. Use of this client will allow MCOs to conduct mainframe sessions to both transmit and view data as is done currently via RLINK.



Once MCOs are linked to the

MDCN, this TN3270 client will be accessed via Microsoft Internet Explorer Version 4.0 (IE 4.0). After the IE 4.0 is launched, the TN3270 site can be brought up to establish a mainframe session. The forthcoming OPL will provide more information regarding this process. IGS will also assist MCOs in the downloading of IE 4.0 and access to the TN3270 client.

Impact to Network Data Mover (NDM) users.

NDM users may continue to utilize this access method to transmit their membership data. It should be noted, however, that the TN3270 client tool will be required for interactive mainframe sessions; i.e., viewing and downloading enrollment and payment reports.

PLAN COMMUNICATIONS ACTION DESKS

Currently, the Health Plan Payment and Operations Support team (HPPOS) has two Action Desks handling all incoming Medicare managed care plan calls. The (HPPOS) action desk

number is (410) 786-7613. All calls from managed care plans that are systems or program support related are to be funneled through the above phone number. The Division of Managed Care Systems (DMCS) action desk at (410) 786-6370 handles data and technical file transfer questions. All calls will be logged and assigned to a plan specialist on our staff.

GUIDELINES AND PROCEDURES FOR RECONCILING MEMBERS WITH ESRD

We are in the process of reissuing a letter to all Medicare+Choice organizations and other interested parties as a reminder of the guidelines and procedures to track ESRD beneficiaries, to reconcile payment, and to emphasize the importance of following these procedures in order to receive accurate payment at the Medicare ESRD capitation rate.

One portion of the letter covers guidelines regulating what the plans can request from the Networks. These guidelines have been revised from a previous letter issued on this subject.

Renal Networks should only provide Plans with the following information:

1) the member's current dialysis/transplant functional status;

2) the first date of dialysis or the date of transplant; and

3) the date the member's HCFA-27228-U4 data was submitted to HCFA.

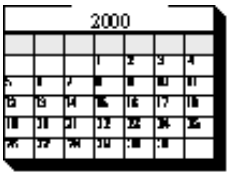
The letter further covers other issues as they pertain to the reconciliation process. Please expect to receive this letter via mail.

YEAR 2000 COMPLIANT

To assure that the Health Care Financing Administration (HCFA) will comply with all compliance standards, HCFA has made Millennium compliance a number one priority for all HCFA systems and related interfaces. This means that all internal and external systems, and interfaces need to be Year 2000 compliant.

Millennium compliance, adapted from the Federal Acquisition Regulation (FAR) 39.002 definitions, means information technology that accurately processes date/time data

(including, but not limited to, calculating, comparing, and sequencing) from, into, and between nineteenth, twentieth and twenty-first centuries, and the year 1999 and 2000 and leap year calculations. Furthermore, Year 2000 compliant information technology, when used in combination with other information technology, will accurately process date/time data if the other information technology property exchanges date/time data with it.



All Managed Care Organizations' (MCOs') systems that interface with HCFA must accommodate January 1, 2000 dates and beyond in such a way that their ability to conduct normal business with us, during and after the century change, is not substantially affected.

On April 1998 we sent an Operational Policy letter (OPL 98- #68) regarding HCFA and plan readiness for the monthly exchange of payment and enrollment data, to conform with the Millennium compliance. HCFA implemented these changes starting with the December 01, 1998 monthly plan submissions. By now all MCOs are to use the revised (03/98) Enrollment/ Disenrollment Transaction record layout and the Transaction Reply/Monthly Activity Report data format record layout.

Other efforts are underway to ensure that MCOs are in full Millennium compliance and to assure all Medicare beneficiaries retain continued access to quality health care in the year 2000 and beyond.

If you would like additional information on this topic, please visit our HCFA home page (http://www.hcfa.gov/medicare/mcoy2k.htm.)

MEMBERSHIP FILE TRANSFERS

Each month, as you prepare your membership update file(s) for transfer to the HCFA Data Center, keep in mind the Plan Transfer Tracking Report available in McCoy (Managed Care Option Information system). Why? Because the file upload and the Plan Transfer Tracking Report are intrinsically linked.

If you submit a file on or before the monthly HCFA cutoff date, HCFA will place that file in its monthly production, right? No, not always. **First** of all the Plan Transfer Tracking Report is a tool available to the plans to accurately verify that the plan's file transfer was received. **Second**, if HCFA received your file transfer, the only date that is acceptable is the process date (e.g., YYYYMM). The process date reflects the next payment to your plan. For example, if you submit a file on or before May 5, 1999 that date would be 199906.

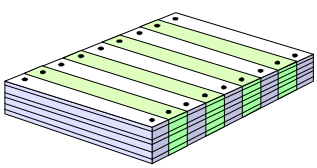
In the Plan Transfer Tracking report screen in McCoy if a second date appears under the process date field, the system would consider this a retro-date (e.g., 199905) and your file transfer will not be placed in production.

When should you verify that HCFA received your file transfer? The Plan Transfer Tracking Report is available for viewing from 5 to 30 minutes after your file is transferred, depending on the current activity. If your file does not appear, then verify that you are requesting to view the correct process month. In our example of a May 6 cutoff date the process month you would request to view would be 06/1999 in McCoy. In the Plan Transfer Tracking Report it would appear as 199906. If your file does not appear then contact

the Division of Managed Care Systems (DMCS) action desk immediately on (410) 786-6370 and provide your USERID, and plan contract number, and the time of your transfer. Of course, don't forget to leave your name, telephone number, and the time of call. If a retro-date is on your file, you must correct the date in your system and resend your file. Again, you must verify that the HCFA has received the file or contact the DMCS action desk immediately. Any questions, regarding this notice may be directed to the Plan Communications action desk at (410) 786-7613.

MONTHLY MEMBERSHIP REPORT

The latest version of the Monthly Membership Report and Summary Report was implemented on April 1, 1998. **Consequently, as of April 1, 1999, we will discontinue the production of several of the existing plan reports.** The reports to be discontinued are the Special Status Report, Beneficiary Adjustment Report, Capitation Report, and the six month Membership History Report. These discontinued reports will not be available in the TSO/GROUCH system.



FUTURE MONTHLY MEMBERSHIP REPORT WITH RISK ADJUSTMENT

The Balanced Budget Act mandated that year 2000 payments to Medicare + Choice (M+C) organizations must be adjusted to reflect the relative risk associated with each member. A risk factor is calculated for each M+C organization's member based, at least initially, upon inpatient hospital diagnostic data. Default factors will be used for new Medicare beneficiaries for which there is no diagnostic data available. Members who are ESRD and hospice will not be risk adjusted. Payments will be a blend of the demographic-based and risk adjustment-based rates. For the year 2000, the payment will be 90 percent of the demographic rate and 10 percent of the risk adjusted rate. HCFA will phase-in to a comprehensive risk adjustment payment methodology--incorporating inpatient, hospital outpatient, and physician data over a five-year period.

The risk adjustment payment methodology will impact the format of some of the Group Health Plan's (GHP) monthly reports, particularly the Monthly Membership Report. HCFA has engaged in discussions with the M+C organizations to determine the revisions to the GHP reports.

As HCFA implements the risk adjustment payment, M+C organizations will be required to provide additional data in order to validate these payments. The current Monthly Membership Report (MMR) contains member-level Part A, Part B and Total demographic payment amounts, as well as the statuses (e.g., ESRD, Hospice, Institutional, etc.) in effect for that month. It also includes any applicable adjustment amounts. The same type of information must be provided to the managed care organizations to describe the risk adjusted portion of the blended payment amount.

Based upon M+C organizations' feedback, it has been decided to revise the MMR to incorporate the new information. It will contain the risk adjustment information for the M+C organization members as well as the risk-equivalent data for nonrisk organization members.

The risk adjustment-based information that is being

considered for inclusion at the member level is:

- Risk Adjustment Factors for Part A and Part B
- PIP-DCG Category
- Previously Disabled Indicator
- Prior-year Medicaid Indicator
- New Enrollee to Medicare Indicator
- Risk Adjustment Payment Rate for Part A and Part B at 100%
- Demographic Payment Rate for Part A and Part B at 100%
- Blended Payment Rate for Part A and Part B and
- Total Payment at the applicable transition year percentage.

The projected plan is to finalize the data and report formats by mid-April 1999 so that the managed care organizations can be notified. We anticipate testing to begin in July 1999. The first risk adjustment blended payments will be computed in December 1999 for January 2000 payments.

OODLES OF DISCOVERIES

HELPFUL HINT: If you are not sure what format (report or data) your **GROUCH** reports are in to download, here are some suggestions:

[**NOTE:** (Refer to Section 7, page 7-7 of the Plan Communications User's Guide for a more detailed explanation of this hint.)]

FILE FORMAT--Report
Put a "**T**" next to the file name you wish to build and leave the (_) mark in the mid-section blank.
Report format will have **headers** and can only be **printed**.

FILE FORMAT--Data
Put a "**T**" next to the file name you wish to build, put a "**D**" in (_) mark in the mid-section.
Data format will be a **continuous flow of data** arranged sequentially that can be interchanged with other applications.

We are working to provide plans with updating capability to enter contact information in our Plan Information Control system (PICS). This will give your plan the opportunity to keep your contact information current in our systems. An Operational policy letter will be released soon, with guidelines and instructions.